Evaluating Trauma-Related Needs, Service Delivery and Outcomes

This document was developed by Julian Ford, PhD (**ford@psychiatry.unhc.edu)** for the *Center for Women, Violence and Trauma* to assist states in developing trauma evaluation plans for mental health systems transformation. For further information, contact the Center at **Women&ViolenceCenterDirector@abtassoc.com.**

I. Background and Overview

Exposure to psychological trauma is prevalent in the community among adults (Kessler et al., 1995), adolescents (Giaconia et al., 1995), and children (Costello et al., 2002), and virtually universal among adults receiving mental health (Mueser et al., 1998) or addiction recovery (Triffleman, 1999) services in public sector systems. One in ten women or girls and one in twenty men or boys in the community experience **post- traumatic stress disorder** (**PTSD**; Kessler et al., 1995; Saigh et al., 1999), but PTSD prevalence is estimated to be 40-50% or higher among youths (Abram et al., 2004) and adults (Briere et al., 1997) These rates do not include partial PTSD, nor do they recognize the likelihood that many persons who experience a traumatic event then develop significant functional and clinical impairments despite not meeting the diagnostic criteria for PTSD (Briere, 1999; Nader, 1997; Newman, 2002).

Moreover, most children and adults who experience trauma do not develop PTSD (Kessler et al., 1995; Saigh, et. al., 1999), but unresolved post-traumatic stress can lead to serious long-term problems in living into and throughout adulthood (Briere, 1997). Adverse consequences include, but are not limited to, **re-victimization, problems with substance abuse, affective disorders, anxiety disorders, dissociative disorders, eating disorders,** and **conduct disorders** (Briere, 1997; Saigh, et. al., 1999).

These long-term post-traumatic dilemmas reflect four fundamental changes that result from exposure to psychological trauma. Traumas are experiences in which a person's **safety**, or that of key caregiver(s) or significant others (e.g., children, siblings or friends), has been compromised. Safety has both an objective (e.g., current or imminent risk of physical or psychological harm) and subjective (e.g., sense of personal safety and trust) dimension. Regaining objective safety is crucial to recovery or healing after trauma, but even when this is accomplished the second fundamental change often remains debilitating.

Surviving the physical danger or violation, and coping with the emotional or spiritual shock and betrayal caused by psychological trauma requires a complex set of adjustments in the body's central and peripheral nervous systems (Bremner, Southwick, & Charney, 1999). In trauma, survival takes precedence over **self-regulation**, and this can result in biological and psychological reactivity which is survival-oriented but which takes a profound toll on bodily health (Boscarino, 1997; Ford et al., 2004) and psychological well-being (Ford, 1999; Herman, 1992) for years or even decades later.

When safety is uncertain (objectively or subjectively), and self-regulation is disrupted, not only the individual but many or most of her or his primary relationships and **social support** system are vulnerable to the adverse effects of unresolved conflict and withdrawal.

The result often is one of many forms of social isolation which reduce the person's access to the practical resources and the interpersonal supports that are essential if a trauma survivor is to both recognize within her/himself and restore or build the **personal strengths** and capacities (e.g., self-esteem and self-efficacy; emotion regulation, problem solving, and communication skills) needed in order to regain safety, self-regulation, and involvement in supportive and productive relationships.

II. Evaluating Trauma-Informed Services

In order to achieve replicable trauma-informed services and to demonstrate their outcomes, a plan for evaluation must include assessment of: (1) the nature and extent of *past and current exposure to psychological trauma and re-victimization*, (2) problems with *PTSD* and *other psychosocial/psychiatric symptoms*, and (3) *current status* and *needs* with respect to *safety, self-regulation, social support,* and *personal strengths.* Both individual and provider interview measures of services utilized and the provider-survivor "working alliance" (such as those developed for the SAMHSA Women, Co-Occurring Disorders, and Violence Study), and archival records (e.g., agency or state computer databases), are needed to assess actual services received.

Multi-Perspective Assessment. Multi-perspective assessment is recommended in order to reduce the likelihood that unintended bias or distortion will occur due to information based on any individual data source. The perspective of the individual herself or himself is important because other informants (e.g., family, teacher, treatment provider, research observer) may focus on overt symptoms or needs while ignoring more subjective symptoms or needs. However, other informants are vital to identify needs, problems, and changes that may not be evident to the individual herself or himself. There is no one "perfect" measure for assessing trauma or post-traumatic sequelae. Measures vary in their reliability, validity, sensitivity, specificity, and clinical utility for different settings and populations. Time permitting, the use of both self-report and interview-based assessments are recommended. Additionally, both structured and semi-structured observational assessments can provide ecologically valid behavior samples (Newman, 2002).

Stages of Evaluation. To maximize the benefits accrued by and the safety of recipients, and the utility of trauma information for both clinicians/case managers and policymakers/system evaluators, a staged approach to collecting data and providing trauma-related education and treatment is recommended. Although the exact stages and sequencing of these trauma-related data collection and education/treatment activities will differ based on feasibility and logistical factors in each different system, project, or program, the phase-based model of complex trauma services (Ford et al., in press) can serve as a guide for trauma-sensitive implementation of trauma-related data collection and services:

- **Phase 1:** Ensure safety and stability, screen for past and current traumatic experiences and symptomatic difficulties without in-depth exploration, provide education about the effects of trauma in a non-stigmatizing, non-pathologizing, and user-friendly manner, and teach/strengthen basic self-regulation skills and social supports.

- **Phase 2:** Assess past and current traumatic experiences and symptomatic and self-regulatory difficulties thoroughly with standardized replicable measures, provide education about the "traumagenic dynamics" (Finkelhor & Browne, 1986) and related alterations in core beliefs, self-regulatory strategies, interpersonal attachments, and spiritual/existential

outlook (Herman, 1992) that begin as healthy self-protective reactions to trauma and can become persistent post-traumatic difficulties, provide a safe therapeutic environment in which the individual can disclose and gain more organized and self-regulated schemas or narratives for understanding current or past trauma-related experiences and problems in living, and teach/strengthen skills for complex self-regulation and interpersonal relatedness.

- **Phase 3**: Monitor current stressful or traumatic experiences, symptoms, self-regulation, social support, and personal strengths/resources on an ongoing periodic basis.

Evaluation Design. As suggested in Phase 3 above, ongoing longitudinal evaluation provides greater clarity concerning the timing, nature, and potential sources of change than simpler traditional pre-post evaluation designs. Data collection and temporal sampling strategies that provide data suitable for longitudinal analyses (e.g., trajectory or growth curve modeling) and analytic plans that account for change over time while adjusting for missing data (e.g., hierarchical linear modeling, random effects regression) are optimal.

A blended qualitative (formative) and quantitative (confirmatory) approach to evaluation is necessary in order to develop screening/assessment and intervention questions and procedures that are sensitive to the primary psychosocial, health, and socioeconomic needs of the target population(s) and to differing norms and practices of sub-populations of different gender, ethnocultural background, developmental status and age, family structure, and type of community/residential environment.

Partnership Models. Involvement of trauma survivors and service recipients as full partners in evaluation is essential. The evaluation team should formally include consumers/survivors/persons in recovery (CSP) as integral staff and investigators in order to ensure that evaluation is grounded in the experience of persons who have lived with trauma and its effects. Hypotheses and logic models, methods and measures for data collection, and approaches to services developed in formative phases of the evaluation should reflect a balance of lived experience and technical expertise, with CSPs often providing both types of expertise. Data collection, analysis, and reporting and dissemination equally should include CSPs as key contributing staff and investigators.

III. Sample Measures

Trauma Exposure/History: Self-Report and Structured Interview (see *www.ncptsd.org*; *www.nctsnet.org*)

- *Childhood Trauma Questionnaire* (Bernstein, et. al., 1994)
- *Traumatic Events Screening Inventory* (TESI; Ford et al., 2000)
- *Life Stressor Checklist-Revised* (Wolfe & Kimerling, 1997)

PTSD Symptoms; Self-Report and Structured Interview (see *www.ncptsd.org*; *www.nctsnet.org*)

- *Clinician Administered PTSD Scale for Children and Adolescents* (CAPS-CA; Newman, 2002) and *Adults* (CAPS, Blake et al., 1995)

- *PTSD Checklist* for adults (PCL-C; Blanchard et al., 1996) and parents (PCL-C/PR; Ford et al., 2000)
- UCLA PTSD Reaction Index for Children (Steinberg et al., 2004)
- PTSD Symptom Scale-Interview (Foa et al., 1993)

Psychosocial and Psychiatric Symptoms: Self-Report and Structured Interview

- *Trauma Symptom Inventory* (adults; TSI; Briere, 1996) and *Trauma Symptom Checklist for Children* (TSCC; Wolpaw, Ford, Newman & Briere, in press))— Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation and Sexual Concerns
- *Diagnostic Interview for Children and Adolesce*nts – Revised (DICA-R; Reich et. al., 1991)
- *Diagnostic Interview Schedule* for adults (DIS; Helzer & Robins, 1988) and for children (DISC; Shaffer et. al., 1992)
- *Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version* () and *Kiddie* version for children and adolescents (K-SADS-PL; Kaufman, et. al., 1997)
- *Structured Clinical Interview for DSM-IV* (SCID-P, SCID-II; First et al., 1996)
- *Global Appraisal of Individual Needs* (GAIN; Dennis et al., in press)—substance abuse, legal and vocational issues, depression, anxiety, demographics (includes GPRA data categories)

Self-Regulation: Self-Report

- *Inventory of Interpersonal Problems-Short Form (IIP-32*) (Barkham, Hardy & Startup, 1996)
- *Post-Traumatic Cognitions Inventory* (PTCI*;* Foa et al., 1999).
- *Generalized Expectancies for Negative Mood Regulation* (NMR; Cantanzaro & Mearns, 1990)
- *Meta-Experience of Mood Scales (*Meta-Scales*;* Mayer & Stevens, 1994)
- *Positive Affect Negative Affect Scales* (PANAS; Watson, Clark, & Tellegen, 1988)
- *Parenting Stress Index Short Form* (PSI; Abidin, 1995)
- *Medical Outcomes Study Short Form-12* (SF=12; Gandek, B., Ware, J.E., Aaronson, N.K., Apolone, G., Bjorner, J.B., Brazier, J.E., Bullinger, M., Kaasa, S., Leplege, A., Prieto, L., & Sullivan, M. (1998). Cross-validation of item selection and scoring for the SF-12 Health Survey in nine countries: results from the IQOLA Project. International Quality of Life Assessment. *Journal of Clinical Epidemiology, 51*, 1171-1178.

Social Support

- *Crisis Support Scale (*CSS; Joseph, Andrews, Williams, & Yule, 1992)
- *Homeless Families Social Support Scale* (www.samhsa.gov; SAMHSA Matrix, Homelessness)

Personal Strengths

- *Hope Scale* (Snyder, 1996)

- *Coping Orientation to Problems Experienced* (COPE, Carver, Scheier, & Weintraub, 1989)
- Relationship Scales Questionnaire & Relationship Questionnaire (Griffin & Bartholomew, 1994)

IV. References

Abidin, R.(1995). *Manual for the Parenting Stress Index.* Psychological Assessment Resources, Inc.

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. McClelland, G., & Dulcan, M. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry, 61,* 403-410.

Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareta, E. & Ruggiero, J., (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry, 151,* 1132-1136.

Blake, D.D., Weathers, F.W., Nagy, L.M., Kaloupek, D.G., Charney, D.S., & Keane, T.M. (1995). *Clinician-Administered PTSD Scale for DSM-IV.* Boston and West Haven, CT: National Center for Posttraumatic Stress Disorder.

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., Forneris, C. A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour Research and Therapy*, 34, 669-673.

Boscarino, J. A. (1997). Diseases among men 20 years after exposure to severe stress. Psychosomatic Medicine, 59, 605-614.

Bremner, J., Southwick, S., & Charney, D. (1995). Etiology of post-traumatic stress disorder. In M. Mazure (Ed.), *Does stress cause mental illness?* (pp. 68-104). Philadelphia: Saunders.

Briere, J. (1997). Psychological assessment of child abuse effects in adults. In J. P. Wilson and T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp. 43-68). New York: Guilford Press.

Briere, J., Woo, R., McRae, B., Foltz, J., & Sitzman, R. (1997). Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients. *Journal of Nervous and Mental Disease, 185,* 95-101.

Costello, E. J., Erkanli, A., Fairbank, J. A., Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15, (2),* 99-112.

Dennis, M.L., Funk, R., Godley, S.H., Godley, M.D., & Waldron, H. (in press). Cross validation of the alcohol use measures in the Global Appraisal of Individual Needs (GAIN) and Timeline Followback (TLFB) among adolescents in substance abuse treatment. *Addiction.*

Foa, E., Riggs, D., Dancu, C., & Rothbaum, B.(1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress,* 6, 459-474.

First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B.W. (1996). *Structured Clinical Interview for Axis I DSM-IV Disorders - Patient Edition (SCID-P).* New York: Biometrics Research Department New York State Psychiatric Institute.

Foa, E.B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. (1999). The Posttraumatic Cognitions Inventory (PCTI): Development and validation. *Psychological Assessment, 11,* 303-314.

Ford, J. D. (1999). PTSD and disorders of extreme stress following war zone military trauma: Comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology, 67,* 3-12.

Ford, J., Courtois, C., van der Hart, O., Nijenhuis, E., & Steele, K. (in press). Treatment of complex post-traumatic self-dysregulation. *Journal of Traumatic Stress.*

Ford, J. D., Racusin, R., Daviss, W. B., Reiser, J., Fleischer, A. & Thomas, J. (2000). Child maltreatment, other trauma exposure, and posttraumatic symptomatology among children with oppositional defiant and attention deficit hyperactivity disorders. *Child Maltreatment, 5,* 205-217.

Ford, J. D., Schnurr, P., Friedman, M., Green, B., Adams, G., & Jex, S. (2004). Posttraumatic stress disorder symptoms and physical health outcomes fifty years after exposure to a toxic gas. *Journal of Traumatic Stress, 17,* 185-194.

Giaconia, R. M., Reinherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K. & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34 (10),* 1369-1380.

Griffin, D. W., & Bartholomew, K. (1994). The Metaphysics of Measurement: The Case of Adult Attachment. In K. Bartholomew & D. P. Perlman (Eds.), *Advances in Personal Relationships: Attachment Processes in Adult Relationships (Vol. 5).* London: Jessica Kingsley.

Helzer, J., & Robins, L. (1988). The diagnostic interview schedule. *Social Psychiatry and Psychiatric Epidemiology, 23,* 6-16.

Joseph, S., Williams, R., & Yule W. (1992). Crisis support, attributional style, coping style, and post-traumatic symptoms. *Personality and Individual Differences, 13,* 1249-1251.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D. & Ryan, N. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry. 36(7),* 980-988.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. Archives of General Psychiatry, 52, 1048-1060.

Mayer, J., & Stevens, A. (1994). An emerging understanding of the reflective (meta-) experience of mood. *Journal of Research in Personality, 28,* 351-374.

Mueser, K.T., Goodman, L.A., Trumbetta, S.L., Rosenberg, S., Osher, F., Vidaver, R., Auciello, P., & Foy, D.W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66,* 493-499.

Nader, K. O. (1997). Assessing traumatic experiences in children. In J. P. Wilson and T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp. 291-348). New York: Guilford Press.

Nader, K., Newman, E., Weathers, F. W., Kaloupek, D. G., Kriegler, J., Blake, D. & Pynoos, R. S. (1998). Clinician-Administered PTSD Scale for children and adolescents (CAPS-CA). White River Junction, VT: National Center for PTSD.

Newman, E. (2002). Assessment of PTSD and trauma exposure in adolescents. *Journal of Aggression, Maltreatment & Trauma,* 6, 59-77.

Reich, W., Shayka, J. J. & Taibleson, C. (1991). Diagnostic Interview for Children and Adolescents (DICA). St. Louis, MO: Washington University.

Saigh, P. A., Yasik, A. E., Sack & W. H., Koplewicz, H. S. (1999). Child-adolescent posttraumatic stress disorder: prevalence, risk factors, and comorbidity. In P. A. Saigh and J. D. Bremner (Eds.), *Posttraumatic Stress Disorder: A Comprehensive Text* (pp. 18-43). Boston: Allyn and Bacon.

Shaffer, D., Fisher, P., Piacentini, J., Schwab-Stone, M. & Wicks, J. (1992). The Diagnostic Interview Schedule for Children (DISC). (Available from authors, Columbia NIMH DISC Training Center, Division of Child and Adolescent Psychiatry-Unit 78, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032).

Steinberg, A., Brymer, M., Decker, K., & Pynoos, R. (2004). The UCLA PTSD Reaction Index. *Current Opinion in Psychiatry, 6,* 96-100.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of Positive and Negative Affect: The PANAS scales. *Journal of Personality and Social Psychology, 54,* 1063-1070.

Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of Posttraumatic Stress Disorder. In J. Wilson & T.M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 192-238). New York: Guilford.